

§411.33

42 CFR Ch. IV (10-1-00 Edition)

(c) *General limitation: Failure to file a proper claim.* When a provider or supplier, or a beneficiary who is not physically or mentally incapacitated, receives a reduced third party payment because of failure to file a proper claim, the Medicare secondary payment may not exceed the amount that would have been payable under §411.33 if the third party payer had paid on the basis of a proper claim.

The provider, supplier, or beneficiary must inform HCFA that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.

§411.33 Amount of Medicare secondary payment.

(a) *Services for which HCFA pays on a Medicare fee schedule or reasonable charge basis.* The Medicare secondary payment is the lowest of the following:

(1) The actual charge by the supplier (or the amount the supplier is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the third party payer.

(2) The amount that Medicare would pay if the services were not covered by a third party payer.

(3) The higher of the Medicare fee schedule, Medicare reasonable charge, or other amount which would be payable under Medicare (without regard to any applicable Medicare deductible or coinsurance amounts) or the third party payer's allowable charge (without regard to any deductible or coinsurance imposed by the policy or plan) minus the amount actually paid by the third party payer.

(b) *Example:* An individual received treatment from a physician for which the physician charged \$175. The third party payer allowed \$150 of the charge and paid 80 percent of this amount or \$120. The Medicare fee schedule for this treatment is \$125. The individual's Part B deductible had been met. As secondary payer, Medicare pays the lowest of the following amounts:

(1) Excess of actual charge minus the third party payment: $\$175 - \$120 = \$55$.

(2) Amount Medicare would pay if the services were not covered by a third party payer: $.80 \times \$125 = \100 .

(3) Third party payer's allowable charge without regard to its coinsurance (since that amount is higher than the Medicare fee schedule in this case) minus amount paid by the third party payer: $\$150 - \$120 = \$30$.

The Medicare payment is \$30.

(c)-(d) [Reserved]

(e) *Services reimbursed on a basis other than fee schedule, reasonable charge, or monthly capitation rate.* The Medicare secondary payment is the lowest of the following:

(1) The gross amount payable by Medicare (that is, the amount payable without considering the effect of the Medicare deductible and coinsurance or the payment by the third party payer), minus the applicable Medicare deductible and coinsurance amounts.

(2) The gross amount payable by Medicare, minus the amount paid by the third party payer.

(3) The provider's charges (or the amount the provider is obligated to accept as payment in full, if that is less than the charges), minus the amount payable by the third party payer.

(4) The provider's charges (or the amount the provider is obligated to accept as payment in full if that is less than the charges), minus the applicable Medicare deductible and coinsurance amounts.

(f) *Examples:* (1) A hospital furnished 7 days of inpatient hospital care in 1987 to a Medicare beneficiary. The provider's charges for Medicare-covered services totaled \$2,800. The third party payer paid \$2,360. No part of the Medicare inpatient hospital deductible of \$520 had been met. If the gross amount payable by Medicare in this case is \$2,700, then as secondary payer, Medicare pays the lowest of the following amounts:

(i) The gross amount payable by Medicare minus the Medicare inpatient hospital deductible: $\$2,700 - \$520 = \$2,180$.

(ii) The gross amount payable by Medicare minus the third party payment: $\$2,700 - \$2,360 = \$340$.

(iii) The provider's charges minus the third party payment: $\$2,800 - \$2,360 = \$440$.

(iv) The provider's charges minus the Medicare deductible: $\$2,800 - \$520 = \$2,280$. Medicare's secondary payment is \$340 and the combined payment made by

the third party payer and Medicare on behalf of the beneficiary is \$2,700. The \$520 deductible was satisfied by the third party payment so that the beneficiary incurred no out-of-pocket expenses.

(2) A hospital furnished 1 day of inpatient hospital care in 1987 to a Medicare beneficiary. The provider's charges for Medicare-covered services totalled \$750. The third party payer paid \$450. No part of the Medicare inpatient hospital deductible had been met previously. The third party payment is credited toward that deductible. If the gross amount payable by Medicare in this case is \$850, then as secondary payer, Medicare pays the lowest of the following amounts:

(i) The gross amount payable by Medicare minus the Medicare deductible: $\$850 - \$520 = \$330$.

(ii) The gross amount payable by Medicare minus the third party payment: $\$850 - \$450 = \$400$.

(iii) The provider's charges minus the third party payment: $\$750 - \$450 = \$300$.

(iv) The provider's charges minus the Medicare deductible: $\$750 - \$520 = \$230$. Medicare's secondary payment is \$230, and the combined payment made by the third party payer and Medicare on behalf of the beneficiary is \$680. The hospital may bill the beneficiary \$70 (the \$520 deductible minus the \$450 third party payment). This fully discharges the beneficiary's deductible obligation.

(3) An ESRD beneficiary received 8 dialysis treatments for which a facility charged \$160 per treatment for a total of \$1,280. No part of the beneficiary's \$75 Part B deductible had been met. The third party payer paid \$1,024 for Medicare-covered services. The composite rate per dialysis treatment at this facility is \$131 or \$1,048 for 8 treatments. As secondary payer, Medicare pays the lowest of the following:

(i) The gross amount payable by Medicare minus the applicable Medicare deductible and coinsurance: $\$1,048 - \$75 - \$194.60 = \778.40 . (The coinsurance is calculated as follows: $\$1,048 \text{ composite rate} - \$75 \text{ deductible} = \$973 \times .20 = \$194.60$).

(ii) The gross amount payable by Medicare minus the third party payment: $\$1,048 - \$1,024 = \$24$.

(iii) The provider's charges minus the third party payment: $\$1,280 - \$1,024 = \$256$.

(iv) The provider's charge minus the Medicare deductible and coinsurance: $\$1,280 - \$75 - \$194.60 = \$1,010.40$. Medicare pays \$24. The beneficiary's Medicare deductible and coinsurance were met by the third party payment.

(4) A hospital furnished 5 days of inpatient care in 1987 to a Medicare beneficiary. The provider's charges for Medicare-covered services were \$4,000 and the gross amount payable was \$3,500. The provider agreed to accept \$3,000 from the third party as payment in full. The third party payer paid \$2,900 due to a deductible requirement under the third party plan. Medicare considers the amount the provider is obligated to accept as full payment (\$3,000) to be the provider charges. The Medicare secondary payment is the lowest of the following:

(i) The gross amount payable by Medicare minus the Medicare inpatient deductible: $\$3,500 - \$520 = \$2,980$.

(ii) The gross amount payable by Medicare minus the third party payment: $\$3,500 - \$2,900 = \$600$.

(iii) The provider's charge minus the third party payment: $\$3,000 - \$2,900 = \$100$.

(iv) The provider's charges minus the Medicare inpatient deductible: $\$3,000 - \$520 = \$2,480$. The Medicare secondary payment is \$100. When Medicare is the secondary payer, the combined payment made by the third party payer and Medicare on behalf of the beneficiary is \$3,000. The beneficiary has no liability for Medicare-covered services since the third party payment satisfied the \$520 deductible.

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§ 411.35 Limitations on charges to a beneficiary or other party when a workers' compensation plan, a no-fault insurer, or an employer group health plan is primary payer.

(a) *Definition.* As used in this section *Medicare-covered services* means services for which Medicare benefits are payable or would be payable except for the Medicare deductible and coinsurance